

Anticipated merger of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Monitor's advice to the Office of Fair Trading under Section 79(5) of the Health and Social Care Act 2012

11 February 2013



**ANTICIPATED MERGER OF POOLE HOSPITAL NHS FOUNDATION TRUST AND
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS
FOUNDATION TRUST**

**MONITOR'S ADVICE TO THE OFFICE OF FAIR TRADING UNDER SECTION 79(5)
OF THE HEALTH AND SOCIAL CARE ACT 2012**

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EXECUTIVE SUMMARY

1. The Office of Fair Trading has notified Monitor that it has decided to carry out an investigation under Part 3 of the Enterprise Act 2002 of the proposed merger of The Royal Bournemouth and Christchurch Hospitals NHS foundation trust and Poole Hospital NHS foundation trust.
2. This is the first time Monitor has provided advice to the Office of Fair Trading on the relevant customer benefits of a merger involving two NHS foundation trust hospitals. Monitor has provided this advice in accordance with the statutory framework set out in the relevant legislation.
3. Our advice on relevant customer benefits is just one of a number of inputs into the decision to be taken by the Office of Fair Trading. The Office of Fair Trading's role is to assess whether there is a competition problem arising from the merger. If the Office of Fair Trading finds such a problem it will take into account Monitor's advice when considering whether there are relevant customer benefits which outweigh that problem. If the merger parties receive competition clearance from the Office of Fair Trading or the Competition Commission, Monitor will review the financial viability of the merged trust and its governance arrangements including a review of the integration plans and quality governance.
4. Monitor acknowledges that the merger parties are seeking to address the challenges of the current financial environment through the merger. Monitor also recognises that local commissioners support the merger. In this advice, Monitor is not expressing a view about whether mergers of hospitals are appropriate or whether this merger is appropriate. Monitor considers relevant customer benefits in relation to each merger proposal on its individual merits. Nor is Monitor expressing any view about what might happen if this merger does not go ahead as planned, or about alternative options that may be available to address changes to the way in which NHS services are provided in the area. This is because we have no statutory power to do so when providing advice on relevant customer benefits to the Office of Fair Trading and because it appears to us that both commissioners and providers in this area are themselves seeking to improve the quality of care provided.
5. We note that commissioners (Dorset Primary Care Trust, Bournemouth and Poole Primary Care Trust and Dorset Clinical Commissioning Group) and NHS South of England have expressed support for the merger. Sir Ian Carruthers OBE, Chief Executive of NHS South of England, submitted that implementation by providers is needed to deliver commissioner plans for the area, and that the merger would be a positive advantage to enable providers to deliver commissioner requirements. Tim Goodson, Chief Officer (Designate) of the Dorset Clinical Commissioning Group, submitted that Dorset Primary Care Trust, Bournemouth and Poole Primary Care Trust and Dorset Clinical Commissioning Group see the merger as key to facilitate and deliver the wider commissioning intentions that are planned in Dorset.
6. The parties submit that the merger is likely to give rise to several relevant customer benefits. They categorise these benefits under four key themes:

- a. Improved quality and safety of services;
 - b. Delivery of financial savings through economies of scale;
 - c. Improved scope of services;
 - d. Enhanced ability to raise capital.
7. The parties propose to reconfigure five services (maternity, haematology, emergency department, acute general surgery, and cardiology) which they submit will improve the quality of those services. The proposed reconfiguration of these services will be subject to consultation requirements under the National Health Service Act 2006 and approval from commissioners and Monitor.
8. Monitor has concluded that the merger is likely deliver relevant customer benefits for some patients in the form of higher quality maternity and cardiology services. Specifically:
- a. Pursuant to the parties' proposed reconfiguration of maternity services, the clinical risks associated with patient transfers [X] will be eliminated [X]. Maternity patients at Poole Hospital NHS foundation trust are also likely to benefit from increased midwife cover. [X].
 - b. Pursuant to the parties' proposed reconfiguration of cardiology services, cardiology patients who would, [X], be treated at Poole Hospital NHS foundation trust are likely to benefit from increased out of hours cover by a consultant cardiologist. We note that this out of hours care will supplement the in hours consultant care these patients already receive regardless of the merger. Further, these benefits may be time-limited, that is, only apply until any broader reconfiguration of patient pathways that occurs as a result of the British Cardiovascular Intervention Society's review of aspects of the local cardiac service.
9. For the reasons set out below in this document, Monitor's view is that it is not appropriate to treat the other benefits submitted by the parties as relevant customer benefits for the purposes of the Office of Fair Trading's assessment under the Enterprise Act 2002.

INTRODUCTION

10. On 22 June 2012, the Office of Fair Trading (OFT) notified Monitor, under section 79(4) of the Health and Social Care Act 2012 (Health and Social Care Act), that the OFT had decided to carry out an investigation under Part 3 of the Enterprise Act 2002 (Enterprise Act) of the proposed merger of The Royal Bournemouth and Christchurch Hospitals NHS foundation trust (Bournemouth) and Poole Hospital NHS foundation trust (Poole) (the merger).
11. Under section 79(5) of the Health and Social Care Act, as soon as reasonably practicable after receiving a notification under section 79(4), Monitor is required to provide the OFT with advice on the following matters:
- a. the effect of the matter under investigation on benefits (in the form of those within section 30(1)(a) of the Enterprise Act (relevant customer benefits)) for people who use health care services provided for the purposes of the NHS, and

- b. such other matters relating to the matter under investigation as Monitor considers appropriate.
12. This document (together with its appendices) constitutes the advice that we must provide under section 79(5) of the Health and Social Care Act. An explanation of the process we undertook to prepare this advice is set out in Annex 1. A non-confidential version of this advice will be published on Monitor's website in due course.
 13. We note that commissioners have expressed support for the merger. NHS South of England submitted that the key factors driving the positive advantage of the merger include the need for single clinical governance systems, single employer systems and shared internal learning from quality improvements, in order to implement the specifications from commissioners and improve services in both Bournemouth and Poole. Dorset Clinical Commissioning Group (CCG) submitted that without the merger the likelihood of the successful delivery of commissioners' intentions is much reduced; indeed the merger is in part the providers responding to meet the commissioning intentions in a way that is sustainable both clinically and financially.
 14. We have had regard to the views of commissioners in preparing this advice. In accordance with our statutory duty we have examined whether the benefits submitted by Bournemouth and Poole (together, the parties) constitute relevant customer benefits within the meaning of the Enterprise Act. The framework of analysis that we have applied is set out below.

FRAMEWORK FOR ANALYSIS OF MERGER BENEFITS

15. In order to constitute a relevant customer benefit within the meaning of the Enterprise Act:
 - a. the benefit must be a benefit to relevant customers in the form of: lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market or markets in which the substantial lessening of competition concerned has, or may have, occurred or (as the case may be) may occur); or greater innovation in relation to such goods or services.
 - b. 'Relevant customers', as defined in the Enterprise Act, include customers of the merger parties, customers of such customers, and future customers.
 - c. In addition, the OFT must believe that the benefit has accrued as a result of the merger or may be expected to accrue within a reasonable period as a result of the merger, and the benefit was, or is, unlikely to accrue without the creation of the merger or a similar lessening of competition.
16. In order for Monitor to assess whether a merger is likely to give rise to relevant customer benefits, merger parties need to identify the benefits that potentially arise from a merger and provide evidence in support of these submissions. This approach reflects the position of the merger parties as the proponents of the transaction and the organisations responsible for ensuring that the intended benefits are realised. This approach is consistent with OFT Guidance which requires merger parties to produce detailed and verifiable evidence of any

anticipated price reductions or other benefits.¹ The views expressed in this advice are based on the evidence which has been presented to Monitor.

17. For Monitor to conclude that a benefit attributed to a merger represents a real improvement in quality of services to patients or value for money, the parties to the merger should be able to describe in sufficient detail the pre-existing situation which the merger will improve. For example, if it is suggested that a merger will improve staffing and provide better coverage of staff absences, then the extent to which existing services suffer from staffing problems should be set out. In the absence of this information, Monitor will find it difficult to form a judgement as to the existence or size of the benefit in question.
18. In relation to clinical benefits arising from a merger, Monitor will seek to evaluate the extent to which the benefit in question results in an improvement in the health outcomes or experience of patients. For example, if it is suggested that a merger will allow a particular type of care or treatment to be carried out at home rather than in hospital, then evidence from the parties would need to explain why this is clinically better for patients, which outcomes this will positively affect, the number of patients this will affect (and which patient groups this improvement might not apply to) as well as the rationale for why this service improvement is not being delivered currently, but will be delivered as a result of the merger.
19. In order to constitute relevant customer benefits under the Enterprise Act, the benefits must be merger specific, that is, they must be unlikely to accrue without the creation of the merger or a similar lessening of competition. This is a question of fact to be determined on a case by case basis. In order to determine whether or not this is the case Monitor will examine whether there is evidence that the submitted benefits are likely to occur in any event, for example whether the parties would have the ability and the incentive to achieve the benefits independently. In circumstances where the parties and commissioners may have separate proposals to make changes to the same services, there is the question of whether any benefits which are submitted as merger specific by the parties are in any event likely to arise within a reasonable period by virtue of commissioner led reconfiguration in the absence of the merger. Monitor will consider whether commissioners would be likely to take action which would have the same effect as the submitted benefit, and how soon that action is likely to occur.
20. We have thought carefully about the commissioner led reconfiguration that might be achieved in the absence of the merger and have only taken account of proposed reconfiguration where plans are sufficiently developed and the evidence demonstrates that the proposed reconfiguration is likely to proceed. Notwithstanding, we note that any reconfiguration process (whether commissioner or provider led) would be subject to consultation.
21. Monitor will have greater confidence that a particular merger benefit is likely to be realised where the parties to a merger have a clear and detailed post-merger implementation plan that sets out how the merger parties' existing structures, processes and practices will be

¹ See OFT, *Mergers: exceptions to the duty to refer and undertakings in lieu of reference guidance* (December 2010 OFT 1122).

modified to realise the benefits in question. Monitor is likely to place greater weight on the credibility of post-merger implementation plans where these plans have not been developed specifically for the purpose of obtaining approval for the merger.

22. In assessing the credibility of any plans to realise merger benefits Monitor may also look to the experience of the merger parties in previous transactions and their success in realising benefits from those mergers. Monitor may also look at other similar transactions and consider whether the parties to those transactions have been successful in realising similar benefits. Monitor will also consider the incentives that the merged trust has to carry out the implementation plans that are presented to it.

ANALYSIS OF MERGER BENEFITS

23. The parties submit that the merger is likely to give rise to several relevant customer benefits. They categorise these benefits under four key themes:
 - a. Improved quality and safety of services;
 - b. Delivery of financial savings through economies of scale;
 - c. Improved scope of services;
 - d. Enhanced ability to raise capital.
24. The specific benefits submitted in relation to each of these themes are discussed in further detail under the relevant headings below.

IMPROVED QUALITY AND SAFETY OF SERVICES

25. The parties identify five services in which they submit that relevant customer benefits, in the form of higher quality services, will be delivered by the merger: maternity; haematology; emergency department; acute general surgery; and cardiology.
26. The parties submit that the quality of these services will be improved by their proposals to reconfigure the services post-merger. It is important to note that any significant change to services needs to comply with public involvement requirements set out in the National Health Service Act, which are discussed further in Annex 2. The parties state that all of their proposals to reconfigure the above services, if the merger is approved, would be subject to NHS consultation requirements.
27. In practice, the duty to involve users in service change may include a number of activities, for example, consultation or providing users with information. Guidance issued by the Department of Health states that users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered.² NHS decision

² Department of Health, *Real involvement: working with people to improve health services* (October 2008).

making practices should be responsive to the concerns of users and able to demonstrate openly how these have been considered and responded to in the decisions made.

28. What form of public engagement is required will depend on the nature of the change proposed. However, typically, engagement with users involves putting options to the public, seeking their views on the proposals and their impact, taking these into account in decision-making and not making any final decisions until engagement with users has occurred.
29. The parties submit that their proposed reconfigurations are not a commitment to specific change, and will only be undertaken after due consideration of their statutory obligations, including a consultation process.
30. We note that because each of the five services which the merger parties propose to reconfigure is a mandatory service under the trusts' terms of authorisation, any variation to those services must be agreed by commissioners and Monitor.
31. We are aware that commissioners in Dorset are in the process of reviewing haematology, emergency department and cardiology services in the area. These proposals are discussed in detail in the relevant sections below.

Maternity Services

32. Currently, Bournemouth and Poole provide separate maternity services at their respective sites. Poole's maternity department admits approximately 4500 mothers per year and offers a midwife led unit co-located with a consultant obstetric service and neonatal intensive care. Bournemouth currently operates a smaller midwife led maternity unit, which admits approximately 500-600 mothers per year. The parties submit that:
 - a. Poole currently has 133 midwives³ which is not enough to comply with Royal College guidance.⁴ They submit that the unit has one of the highest occupancy rates in the country (around 95%).⁵ Its midwife to mother ratio is 1 midwife: 33.5 mothers, which is less than the ratio of 1:31 that was set by the 'birth rate plus' assessment of midwifery staffing which Poole completed in February 2012. The parties further submit that the current building at Poole requires investment for refurbishment or demolition and reconstruction, as its size will be insufficient to meet demand in East Dorset in the near future.
 - b. Bournemouth currently has 38.57 midwives;⁶ the parties submit that the minimum number required to operate the unit safely is 38.5. The parties told us that the number of midwives staffing the Bournemouth maternity unit [38] is required to provide safe

³ This number represents the whole time equivalent.

⁴ A paper published by the The Royal College of Midwives recommended that each maternity unit measure its requirements using the 'Birthrate Plus' tool (Ball J A, Washbrook M, *Birthrate plus: a framework for workforce planning and decision making in maternity services* (1996)) as this allows providers to assess their optimum midwife to women ratio taking account of intrapartum case mix categories (see The Royal College of Midwives, *guidance paper: staffing standard in midwifery services* (No. 7 May 2009).

⁵ See Midwives Magazine, *All part of the equation* (issue 1, 2012).

⁶ This number represents the whole time equivalent.

cover. The parties further submit that the unit is loss making and sub-scale. Around 31% of maternity patients at Bournemouth require transfer to Poole each year as a result of complications developing during labour, after delivery or identified during antenatal care.

33. Post-merger the parties propose to [X]. The proposed reconfiguration would be subject to the consultation requirements outlined in Annex 2. In order to [X], and to meet future demand in the area, the parties propose to upgrade the Poole facility, which they submit will cost between £[X] and £[X] million. The parties submit that the reconfiguration of maternity services will be completed in two phases:
 - a. Phase 1, involving the refurbishment [X].⁷
 - b. Phase 2, involving the redevelopment or relocation [X].
34. The parties submit that the proposed reconfiguration of maternity services will deliver the following benefits to patients:
 - a. Eliminate patient transfers [X].⁸
 - b. Enable the parties to combine their midwife rota to provide increased cover [X].
35. The parties have no plans to reduce the number of patient transfers or to improve midwife cover prior to the completion of phase 1 of the proposed reconfiguration.
36. The parties submit that mothers who wish to be treated in a midwife led unit will have the option [X]. The parties further submit that combining the midwife rota will enable them to increase the availability of [X].

Monitor's view

37. There is guidance from the Royal College of Midwives which determines the recommended ratio of midwives to mothers that is required to deliver a safe and high quality maternity service to mothers.⁹ There is also clinical evidence that transfer during labour presents risk to both mother and foetus.¹⁰
38. If the proposed reconfiguration proceeds in the manner anticipated by the merger parties, around [X] patients (based on current figures) may benefit as they will no longer require transfer [X]. However, we note that [X]. For the purposes of this advice in the time

⁷ The parties expect the merger to complete between April and July 2013, subject to satisfaction of the conditions precedent.

⁸ [X].

⁹ See footnote 4 above.

¹⁰ A study found that transfers due to complications during labour or immediately after birth present an increased risk of an adverse outcome for the baby (9.3 adverse perinatal outcomes per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units). See *The Birthplace in England Research Programme, 2008-2010* - jointly funded by the National Institute for Health Research (NIHR) Service Delivery and Organisation programme and the Department of Health Policy Research Programme.

available we have not been able to assess this further although we anticipate that the issue would be considered as part of any consultation process.

39. It appears to us that by pooling midwife resources [redacted],¹¹ the parties would be better able to utilise their combined midwife capacity. In this regard, we note that [redacted]. Bournemouth's unit is open 24 hours a day, 7 days a week, with two midwives on duty as a requirement.
40. Patients at Poole may benefit from increased midwife cover [redacted]. However, the possible benefits to patients are dependent on the merged trust being able to finance refurbishment of Poole's maternity unit.
41. The parties submit that the refurbishment will be funded as part of the overall capital programme of the merged trust. The total capital programme for the merged trust for 5 years from 2013/14 will cost around £100 million, which will be funded by a combination of the parties' existing cash reserves and cash generated through normal trading.¹² No borrowing is anticipated.
42. On the basis of the parties' submission that the merged trust will have sufficient funds to refurbish the unit without needing to borrow funds, and that this will be completed within the second year following the merger, it appears to us that the refurbishment may be expected to be completed within a reasonable period following the merger. It appears to us that the merged trust is likely to have an incentive to undertake the refurbishment of the unit given the current capacity constraints at Poole and [redacted]. We note that the delivery of the submitted benefits to patients will depend on the outcome of a consultation process regarding the proposed reconfiguration, [redacted]¹³.
43. In order to constitute relevant customer benefits under the Enterprise Act, the benefits must be merger specific.¹⁴ In order to determine whether the submitted benefits in relation to maternity are merger specific we have considered whether the benefits would be likely to be delivered by any of the following alternatives to the merger: commissioner led reconfiguration of maternity services; Poole refurbishing its maternity unit independently; Bournemouth expanding its unit independently; closing the Bournemouth midwife led unit; employing more midwives at Poole; entering into a service level agreement to combine the midwife rota or [redacted]; or merging with an alternative partner.
 - a. *Commissioner led reconfiguration of maternity services:* we note that commissioners do not have current reconfiguration plans with respect to maternity services and the matter has not been formally considered by the NHS Bournemouth and Poole Primary Care Trust (PCT) or Dorset Shadow CCG. However, commissioners told us that they recognised that there was an issue with the age of the estate at Poole's maternity unit.

¹¹ [redacted].

¹² The parties submit that the merged trust is expected to generate operating surpluses over the first 5 years post-merger, with opening cash balances of over £50 million and a baseline depreciation budget of approximately £20 million per annum.

¹³ [redacted].

¹⁴ See paragraph 19 above.

Commissioners said they would be looking to the capital resources of the merged organisation to fund the expansion of Poole's maternity unit as this is a provider issue, but commissioners would have to consider this position if that funding does not go ahead.

In circumstances where commissioners are not currently undertaking a reconfiguration process with respect to maternity services, it appears to us that in the absence of the merger it is unlikely that the benefits would be delivered by commissioner led reconfiguration as quickly as they would by the reconfiguration proposed by the parties.

- b. *Refurbishment of Poole's maternity unit on a stand-alone basis:* the parties submit that absent the merger, Poole will [§<]. We note that Poole's annual report and accounts for financial year 2011/12 indicate that the trust invested £700,000 in the upgrade of its two maternity theatres, which was completed in December 2011. The Board has also committed a further £2 million to a major refurbishment of the building. However, Poole's annual report also indicates that the trust's long term strategy is to relocate maternity services to a new building, and says that this will not be achievable on a stand-alone basis within the next four to five years.

The parties submit that in the absence of the merger Poole would not be able to borrow to pay for [§<]. The parties told us that Poole could not raise funding by entering into a joint venture arrangement with a third party because [§<], with the amount of investment needed making a commercial return unlikely. A joint venture arrangement would also require a partner to invest funds on the basis of future payments from that investment.

We asked the parties why the merged trust would have an incentive to invest in the unit if it would not be a profitable investment for a joint venture partner. The parties submit that because the merged trust will have the necessary internal reserves it does not need to demonstrate a commercial return on investment specifically in maternity. Further the parties submit that because maternity is an essential service to the local health economy the merged trust could not close the service just because it does not generate a return under the current tariff.

Given [§<] it is likely to be more expensive for Poole to invest in refurbishing its maternity unit on a stand-alone basis in the absence of the merger. Therefore it appears to us that this benefit is less likely to occur as a result of refurbishment of Poole's maternity unit on a stand-alone basis than it would be under the reconfiguration proposed by the parties.

- c. *Expansion of Bournemouth's midwife led unit:* In order to operate an obstetric unit that replaces the unit at Poole, Bournemouth submits that it would need to make a £[§<] million capital investment. This would fund an obstetric and neonatal intensive care unit. Bournemouth submits that it is unlikely to have the incentive to make a £[§<] million capital investment as a stand-alone organisation, and that the NHS tariff for maternity services is not sufficient to make this financially worthwhile. It submits that it

is the combined patient volume of the joint organisation and the clinical links that would make such investment worthwhile post-merger. In addition, Bournemouth submits that the investment and development potential for maternity is to the west rather than the east due to the presence and influence of Southampton Hospital NHS foundation trust.

It appears to us that Bournemouth is unlikely to have a strong incentive to expand its maternity unit in the absence of the merger in circumstances where it does not currently offer a consultant led service and the commercial return on maternity services is not strong. We also note that in order to increase its volumes significantly it is likely Bournemouth would need to attract patients away from the established facility at Poole. Therefore it appears to us that this benefit is more likely to occur as a result of the reconfiguration proposed by the parties.

- d. *Closing Bournemouth's midwife led unit:* Although [redacted], Poole would be unlikely to have the capacity to take on all of Bournemouth's patients if it were to close. It would accordingly be necessary for Bournemouth's patients to attend other trusts which may be located considerably further away. It therefore appears to us that this would not be likely to give rise to the same benefits as the reconfiguration proposed by the parties.
- e. *Employing more midwives at Poole:* the parties submit that they are unable to employ more midwives because there is a national shortage of midwives. This shortage has been documented.¹⁵ On this basis, we consider that this may not be a feasible alternative in the absence of the merger without additional investment. In any event, employing more midwives at Poole would not eliminate transfers from Bournemouth, or expand bed capacity at Poole. It therefore appears to us that this would not be likely to give rise to the same benefits as the reconfiguration proposed by the parties.
- f. *Entering into a service level agreement to combine the midwife rota or [redacted]:* It appears to us that combining the midwife rota pursuant to a service level agreement is unlikely to be feasible if [redacted]. It therefore appears to us that this would not be likely to give rise to the same benefits as the reconfiguration proposed by the parties.
- g. *Merger with an alternative provider:* we considered whether merger or acquisition by another provider with access to capital would enable the funding of the redevelopment of Poole's obstetric unit. The parties submit that if the merger does not proceed, the parties are likely to remain independent. It appears to us that in principle this benefit could be achieved by a merger with another provider with access to sufficient capital to enable redevelopment of the Poole facility. However, for the purposes of this advice we are not able to conclude on the likelihood of such an alternative merger.

¹⁵ See the Royal College of Midwives e-petition which called for 5000 more midwives nationally; Care Quality Commission, *Market report* (Issue 1: June 2012).

44. For the reasons set out above Monitor's view is that the merger is likely to deliver relevant customer benefits for some patients in the form of higher quality maternity services. Specifically:
- a. Transfers [X] are likely to be eliminated. [X].
 - b. Patients at Poole are likely to have increased midwife cover [X].

Haematology Services

45. The parties currently provide separate haematology services.¹⁶ The British Committee for Standards in Haematology (BCSH) specifies different levels of care within haematology services. Level 3 services relate to complex treatments designed for rare haematological malignancies with a high incidence of complications.¹⁷ Bournemouth and Poole both currently provide separate level 3 haematology services, in addition to lower level, less complex (level 2)¹⁸ haematology services.
46. Haematology services are provided by 3.5 whole time equivalent consultants at Poole and 6 consultants at Bournemouth. The parties see a combined total of 23,000 haematology patients annually, with 33% of those seen at Poole. Both hospitals have 14 beds each, and perform 10-13 bone marrow transplants a year each. The parties argue that both trusts face significant challenges and will find it difficult to develop their services to the standard of centres of excellence¹⁹ in the absence of the merger. In particular, [X].
47. Post-merger, the parties propose to [X]. They propose to [X]. The parties submit that refurbishment will require investment of around £[X] million. The proposed reconfiguration would be subject to the consultation requirements outlined in Annex 2. The parties submit that the proposed reconfiguration will deliver the following benefits:
- a. Enable the parties to combine their rota [X].
 - b. Enable the parties to comply with National Institute for Clinical Excellence (NICE) outcomes guidance regarding the minimum scale for treatment of haemato-oncological cancers, and recent National Cancer Peer Review Programme measures requiring

¹⁶ Haematology is the diagnosis, treatment and prevention of diseases of the blood and blood-forming organs (such as bone marrow), as well as the immunological, haemostatic (blood-clotting) and vascular systems. Haemato-oncology is the specialist diagnosis and treatment of patients with haematological malignancies.

¹⁷ BCSH haemato-oncology task force, *Facilities for the treatment of adults with haematological malignancies – levels of care* (April 2010).

¹⁸ Level 2 inpatient services relate to treatments causing periods of neutropenia (neutropenia refers to an abnormally low number of a certain type of white blood cells) which are less complex than level 3 treatments. BCSH haemato-oncology task force, *Facilities for the treatment of adults with haematological malignancies – levels of care* (April 2010).

¹⁹ Monitor understands that there is no nationally agreed definition or certification process to create a centre of excellence, however Monitor is aware that the majority of institutions and their clinicians develop centres of excellence more successfully to carry out three primary missions: provision of the highest quality specialist clinical services, teaching, and research. These centres can be recognised by specialist commissioners and for some services there is a process of designation.

specialist haematological laboratories to cover a catchment population of at least 2 million,²⁰ consequently improving mortality and morbidity.

- c. Savings of £[X] million in operational costs associated with outpatient work, for example by rationalising laboratories.
48. The parties submit that [X] haematology services will be completed within the second year following the merger.
49. The parties submit that both trusts fail to meet the minimum catchment area of 500,000 population required by NICE outcomes guidance for haemato-oncology cancers.²¹ National guidance expects specialist haematology to be increasingly centralised and specialist haematological laboratories to cover a catchment population of at least 2 million.²²
50. The parties submit that the merged trust will service an expanded catchment area of over 850,000, but that this catchment area is sufficient to establish a centralised haematological laboratory due to the demographics of the population.²³
51. Commissioners in Dorset have told us that they will not continue to fund two separate level 3 inpatient haematology services at both trusts. We understand that commissioners plan to centralise level 3 haematology services in the area to provide a hub and spoke model of care. These plans are well developed, with consultation on a single level 3 service having been undertaken and agreed by stakeholders. Commissioners have published a draft service specification indicating that Dorset will in future have a single BCSH level 3 inpatient haematology service operating as a single designated centre providing elective and non-elective inpatient care for people with complex haematological disorders. Other outpatient services will link from other hospitals and community based services as spokes to a fully networked service. Commissioners submit that it would be desirable to locate the single level 3 inpatient haematology service on a site from which oncology and radiotherapy services are also provided. Commissioners further submit that it is likely that level 2 inpatient services²⁴ will also need to be consolidated to a single provider with level 3 services in order to make the whole service viable.
52. We expect the commissioners' proposed reconfiguration of haematology services to occur regardless of the merger. The parties told us that commissioners have confirmed that failure to deliver a local viable solution within the short to medium term will result in the wider tendering of services for adults requiring BCSH level 3 care.

²⁰ National Cancer Action Team, *National cancer peer review programme, manual for cancer services: haematology measures* (issued June 2012).

²¹ NICE, *Guidance on cancer services – improving outcomes in haematological cancers – the manual* (2003).

²² See footnote 20.

²³ In support of this submission, the parties submitted a record of a meeting of the East Dorset Haematology Service's Expert Reference Panel at which Professor Adrian Newland said that the service has enough work to make it viable because the Dorset population is 'skewed' in terms of a diagnostic population.

²⁴ Bournemouth and Poole both currently provide level 2 services [X].

53. The parties submit that in the absence of the merger, and in light of commissioners' plans, the following alternatives would be open to each of the trusts in order to ensure the continuation of services:
- a. Poole could bid for a single level 3 haematology service with an expanded haematology unit on a stand-alone basis. However, the parties submit that this is unlikely because, [X], Poole cannot independently fund the additional investment required (around £[X] million) to expand its service to treat all patients in a single centre. The parties submit that if Poole does not bid for the service, commissioners lose the choice of locating the service at Poole, and thereby the potential benefit of co-locating the haematology service with oncology and radiotherapy services.²⁵
 - b. Bournemouth and Poole could bid together for the single level 3 haematology service with a centralised haematology unit which uses the existing consultant resources available at the two trusts. The parties argue that co-operation or service agreements between the trusts would not enable them to consolidate the service in the same way as the merger as it is difficult to align the incentives of both trusts because one party would lose the revenue associated with the service. Currently haematology services provide £0.3 million of annual revenue for Bournemouth and £1.3 million for Poole. The parties submit that previous attempts to combine the haematology service have failed because removing the haematology service from one of the sites would have direct implications on the clinical work across that site.

Monitor's view

54. Commissioners have identified a clear rationale for delivering this service from a single site for the area, with benefits from having out of hours access to this highly specialist service for cancer patients. However, in light of the well developed commissioner plans to consolidate haematology services in the area and commissioners' clear intention to commission only one acute provider for level 3 inpatient haematology services and specialised haematology laboratory services, Monitor is not satisfied that the benefits to patients of having access to a centre of excellence would be unlikely to accrue without the merger. In addition, as commissioners have not yet identified which facility should host the inpatient haematology service, the parties' proposal [X] may conflict with commissioner plans [X].
55. We do not agree with the parties' submission that, without the merger, commissioners will lose the choice of locating the haematology service at Poole. It appears to us that in the absence of the merger it is for Poole to assess whether the potential revenue from providing the service warrants investment in expanding its facility to bid on a stand-alone basis. Alternatively, it would be possible for Poole to bid jointly with another provider (for example Bournemouth) to operate the service.
56. In any event, in our view it is for commissioners to decide who is the best placed provider of the service. Improving Poole's ability to bid for the service does not, in our view, constitute a

²⁵ We note that oncology and radiotherapy services are currently provided by Poole, but not Bournemouth.

relevant customer benefit. To the extent that the merger may reduce competition between potential bidders for the service this is a matter relevant to the assessment of whether the merger substantially lessens competition, and is outside the scope of this advice. Monitor's view is that the parties' proposed reconfiguration of haematology services is not a relevant customer benefit as it is not specific to the merger and is likely to occur regardless of the merger.

Emergency Department Services

57. Currently the parties provide emergency department services from both sites. Poole receives around 60,000 patients and Bournemouth receives around 52,000 patients in its emergency department each year. Both trusts provide an emergency medicine consultant presence 12 hours per day during the week and 4 hours per day during the weekend. Outside of these hours, consultant input is provided on an on-call off site basis under a shared rota.²⁶ The parties told us that each trust is planning to increase their number of consultants by one (from 5 at each trust to 6 at each trust) in the short term regardless of the merger, which will enable them to offer an increased consultant presence in the emergency department to twelve hours per day during the week and nine hours per day during the weekend.
58. The parties state that even with this increased consultant input neither trust will be able to achieve the standard national requirements developed by the College of Emergency Medicine.²⁷ These standards recommend a minimum of 10 consultants per emergency department with up to 80,000 attendances per year, and a minimum of 16 hours consultant presence per day (including weekends). The recommended number of consultants for emergency departments seeing between 80,000 and 100,000 attendances per year is 12 consultants, rising to 18 consultants if the department is also a major trauma centre and requires consultant presence around the clock rather than for 16 hours per day. For departments in excess of 100,000 attendances the College recommends 16 consultants are needed to deliver a consultant presence 16 hours per day.
59. In addition the parties submit they are facing a national lack of senior and middle grade staff, which makes it difficult to comply with the General Medical Council's guidance regarding supervision of junior doctors.²⁸ The parties submit that the gaps in the provision of an adequate rota are likely to increase in future, due to the reduction in training for middle grade doctors²⁹ and the rising demand for emergency care.

²⁶ The out of hours emergency department consultant cover is provided by one consultant who is on-call (off site) for both emergency departments. The parties submit that [redacted].

²⁷ The College of Emergency Medicine, *Emergency medicine consultants, workforce recommendations* (April 2010).

²⁸ General Medical Council, *Leadership and management for all doctors* (January 2012). This guidance states that doctors must make sure that the people they manage have appropriate supervision, whether through close personal supervision (for junior doctors, for example) or through a managed system with clear reporting structures.

²⁹ See Foundation Trust network review body on doctors' and dentists' remuneration, *Review for 2013/14: written evidence for the foundation trust network* (September 2012).

60. Post-merger the parties propose to reconfigure their emergency departments. Any reconfiguration would be subject to the consultation requirements outlined in Annex 2. The parties submit that the reconfigured service may take one of the following forms:
- a. [REDACTED]
 - b. [REDACTED]
 - c. [REDACTED]
61. The parties submit that their reconfiguration of emergency department services is likely to be completed within the third year following the merger. Under the current emergency department rota, consultants are on call for 1 day every 5 days; post-merger, [REDACTED].
62. The parties submit that the proposed reconfiguration will deliver the following benefits:
- a. Provide increased consultant cover [REDACTED].
 - b. Ensure closer supervision of junior doctors by sharing middle grade staff across the trusts.
 - c. Deliver savings due [REDACTED]. However, the parties do not quantify the savings that are likely to be achieved.
63. The parties put forward evidence to support the view that consultant delivered care produces benefits for patients.³⁰ The parties also told us there is evidence at national level that suggests by complying with the new national standards on service coverage arrangements it is possible to improve mortality and morbidity levels through a reduction in the inequality of treatment of patients in and out of hours.
64. The parties submit that the proposed reconfiguration will increase the catchment area for their emergency departments consistent with guidance from The Royal College of Surgeons of England, which suggests that elective and emergency medical and surgical services should be organised for a population of 450,000 to 500,000.³¹ In support of this recommendation the guidance relies on a 1998 report³² which has since been superseded by a 2011 report by the Royal College.³³ We note that the 2011 report does not specify what a sufficient catchment size would be.
65. The parties submit that in the absence of the merger, increasing emergency department consultants at each site on a stand-alone basis would not be feasible. They submit that each

³⁰ A report published by the Academy of Medical Royal Colleges in January 2012 entitled 'The Benefits of Consultant Delivered Care' examined the evidence and conducted a systematic review of literature published between 1992 and 2011 which demonstrated that increased consultant cover improved outcomes for patients by enabling rapid and appropriate decision making.

³¹ The Royal College of Surgeons of England, *Delivering High-quality Surgical Services for the Future* (2006).

³² The Royal College of Surgeons of England, *Provision of Acute General Hospital Services* (July 1998).

³³ The Royal College of Surgeons of England, *Emergency Surgery, Standards for unscheduled surgical care: Guidance for providers, commissioners, and service planners* (February 2011).

trust would need to employ 5-6 additional consultants, at a cost of around £1 million to the trust. The parties submit that this would reduce the current contribution of Bournemouth's emergency department (currently £[redacted] million) [redacted] and further deteriorate the profitability of the emergency department at Poole (currently -£[redacted] million).

66. The parties submit that it is not possible to [redacted] absent the merger for the following reasons:
- a. Emergency department performance has a significant impact on governance ratings, for example, if 4 hour waiting time thresholds are breached, the trust may incur a red risk rating from Monitor and fines from commissioners. If there remain separate boards and management teams accountability could not be assigned to one trust or the other.
 - b. The parties already have a joint rota but it is not in their commercial interests to co-operate further [redacted] pursuant to a service level agreement. The parties submit that currently, the parties' emergency departments provide a significant source of revenue and an avenue for patients to be admitted. [redacted].
 - c. The parties submit that commissioners are unlikely to seek, through the commissioning process, to [redacted]. The parties submit that the merger will allow [redacted] to occur more quickly and with greater certainty, and does not risk the sustainability of interrelated services at either trust.
67. We understand that commissioners in Dorset are currently undertaking a review of urgent care in the area and have appointed a Project Board to conduct the review. The project will be conducted in three phases:
- a. Phase 1 will involve a review of urgent care services across Dorset, Bournemouth and Poole in consultation with stakeholders. The review will examine current process and functional systems, local best practice and early indicators of success with a view to identifying where changes would bring about service improvement.
 - b. Phase 2 will involve involving drawing up proposals, based on the outcomes from phase 1, for any immediate minor changes and new models of care and service configuration considered to be apposite to future needs. Consultation will take place on these proposals and final recommendations will be presented to the pan-Dorset Clinical Commissioning Group.
 - c. Phase 3 will involve the development of service specifications designed to deliver commissioners' intentions via incorporation into future contracts. Any necessary minor variations to current service contracts will be identified and implemented from April 2013. Major changes will be planned during 2013 for full implementation from 2014 onwards.
68. Commissioners told us that what they are seeking is a consistent approach to urgent care on a round the clock basis across the county. The urgent care review is a far reaching review across the whole spectrum of urgent care including primary care, out of hours care, community services and acute services.

69. Phase 2 of the review will include drawing up proposals for service configuration that would be subject to a consultation process. We understand that the implementation of recommendations of the urgent care review is expected to occur from 2014 onwards. Any reconfiguration of emergency department services, which are a mandatory service under the parties' terms of authorisation, would require a separate consultation process and commissioner consent.

Monitor's view

70. There is sound evidence for the argument that creating a comprehensive consultant presence and cover for emergency departments which is compliant with national standards provides benefits to patients in terms of senior clinical input and care around the clock.
71. However, we note that [redacted]. The parties state that the merged trust could absorb the cost of hiring additional consultants to provide the requisite cover but they have not explained how they propose to fund the additional positions.
72. We note that the delivery of the submitted benefits is dependent upon [redacted]³⁴. For the purposes of this advice in the time available we are not able to assess whether the potential clinical benefits of [redacted]; in our view it is appropriate for such matters to be dealt with fully during a consultation process on any reconfiguration.
73. We also have some doubts about the likelihood of increased consultant cover being realised by the options proposed. Specifically:
- a. Neither party would [redacted].³⁵
 - b. If one of the emergency departments [redacted].
74. In any event the commissioner led review of urgent care in Dorset (discussed at paragraph 67 above) will occur regardless of the merger and is intended to determine the best way to deliver improved patient outcomes in unscheduled care.³⁶ In our view, this review and its outcomes are likely to inform what the requirements should be for dealing with patients who require treatment urgently in various settings (for example, primary, secondary and community), including emergency care and emergency departments across the area. Any reconfiguration of emergency departments would need to be consistent with the outcome of this review.

³⁴ [redacted].

³⁵ [redacted].

³⁶ As we understand it, urgent care is unscheduled care and includes both daytime and out-of-hours General Practitioner visits in the community, as well as emergency 999 ambulance response and rapid access care. Urgent care may be provided by a range of professionals across all settings and is delivered in a number of different forms. Settings may include, but are not limited to, primary, secondary, and community-based services.

75. In these circumstances, we are not satisfied that the parties' proposed reconfiguration of their emergency departments would be likely to deliver relevant customer benefits. Specifically:
- a. [redacted];
 - b. [redacted];
 - c. [redacted].
76. In our view, it would also be necessary for any reconfiguration of emergency departments to be consistent with the needs of the local population and area-wide outcomes for service delivery that are determined by the urgent care review.
77. Accordingly, we conclude that the merger is unlikely to give rise to relevant customer benefits in the form of higher quality emergency department services.
78. In relation to the parties' submitted benefits regarding closer supervision of junior doctors and savings, the parties have not provided detail such as the numbers of middle grade doctors likely to be shared between the trusts, or the quantity of savings that will be delivered. Accordingly, we consider that there is insufficient evidence to accept these submitted benefits.

Acute General Surgery Services

79. The parties currently provide separate acute general surgery services. Poole currently has 5.5 whole time equivalent acute general surgery consultants and Bournemouth has 8. The parties submit that neither of them has sufficient consultants to offer:
- a. a consultant led service in which the consultants have no elective commitment during their emergency on call time (consistent with Royal College standards);³⁷ and
 - b. an all-day CEPOD (dedicated theatre on standby for emergency surgery).³⁸
80. The parties submit that a reduction in middle grade training numbers is also putting the acute surgery rotas for both trusts at risk.
81. Post-merger the parties propose to [redacted]. The proposed reconfiguration would be subject to the consultation requirements outlined in Annex 2. The parties have not yet identified [redacted].
82. In the case of Poole, acute general surgery is required to support: paediatrics; trauma orthopaedics; the emergency department (East Dorset Trauma Unit); and emergency gynaecology. In the case of Bournemouth, acute general surgery is required to support vascular services and urology services.

³⁷ The Royal College of Surgeons of England, *Emergency Surgery, Standards for unscheduled surgical care: Guidance for providers, commissioners, and service planners* (February 2011).

³⁸ CEPOD list refers to the emergency operating list, as opposed to the planned operation list. The expression is derived from NCEPOD (National Confidential Enquiry into Patient Outcome and Death), an organisation which has defined a classification of interventions according to their urgency.

83. The parties submit that the reconfiguration of acute general surgery is likely to be completed within the first year following the merger and is not dependent on their proposed emergency department reconfiguration (in the third year following the merger).
84. The parties submit that by pooling resources across both trusts, the proposed reconfiguration will deliver the following benefits:
- a. The merged trust will be able to relieve consultants of their elective activity when they are on call, ensuring the trust complies with Royal College standards. A dedicated surgeon with no elective commitment would be available [§<] from 8am to 7pm to see emergency patients and lead on the CEPOD list. The parties submit that this will improve mortality by providing patients with more rapid access to consultant review and an emergency theatre.
 - b. Enable the parties to have a dedicated CEPOD theatre available 24 hours a day, 7 days a week.
 - c. Compensate for the reduction in middle grade doctor training numbers by combining trainee surgeons onto a single rota.
85. In support of their submissions with respect to acute general surgery, the parties have cited Royal College of Surgeons standards for the provision of unscheduled surgical care. This guidance has been produced after recognition that in many instances the delivery of emergency surgical care is currently sub-optimal, for example nationally the mortality from major abdominal surgical emergencies stands at 25%, but this varies two-fold between different surgical units.³⁹ The parties told us it is known that the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at a weekend rather than during the week.⁴⁰ The evidence suggests that compliance with the Royal College standards would result in improved patient care and outcomes, for example critically ill patients will have priority over elective patients for CEPOD surgery, all ‘high risk’ patients will have their operation carried out under direct supervision of a consultant surgeon, and emergency and elective surgical care pathways will be separated.

³⁹ In the UK, 170,000 patients undergo higher risk non-cardiac surgery each year. Of these patients, 100,000 will develop significant complications resulting in over 25,000 deaths. General surgical emergency admissions are the largest group of all surgical admissions to UK hospitals and account for a large percentage of all surgical deaths. Emergency cases alone presently account for 14,000 admissions to intensive care in England and Wales annually. The mortality of these cases is over 25%. Studies from the UK suggest that a readily identified higher risk sub-group accounts for over 80% of post-operative deaths but less than 15% of inpatient procedures. Advanced age, co-morbid disease, and major and urgent surgery are the key factors associated with increased risk. Within this group, emergency major gastrointestinal (GI) surgery has one of the highest mortalities, which can reach 50% in the over 80s. See The Royal College of Surgeons of England and Department of Health, *The Higher Risk General Surgical Patient Towards Improved Care for a Forgotten Group’ Report on the Peri-operative Care of the Higher Risk General Surgical Patient* (2011).

⁴⁰ The Royal College of Surgeons of England and Department of Health, *The Higher Risk General Surgical Patient Towards Improved Care for a Forgotten Group’ Report on the Peri-operative Care of the Higher Risk General Surgical Patient* (2011); Aylin P, Yunus A, Bottle A et al, Weekend mortality for emergency admissions: A large, multicentre study (2010); NHS London, *Adult emergency services: acute medicine and emergency general surgery, case for change summary* (September 2012).

86. The parties submit that the benefits are unlikely to be delivered in the absence of the merger for the following reasons:
- a. Without an increased demand for elective general surgical care it would not be feasible to increase consultant numbers independently across both sites to comply with national standards. The parties would need to employ trust grade doctors to make the current separate rotas sustainable and increase consultant numbers to staff an out of hours consultant led service while maintaining quality of care to elective surgical patients. They submit that creating a combined on call rota for acute surgery is only possible with the critical mass of surgeons across the two trusts, sufficient for a sustainable rota around the clock.
 - b. It would not be possible to [redacted].
 - c. The parties have attempted to combine the on call service in general surgery but these attempts have been unsuccessful because the impact on their elective workload would be financially damaging to the parties and it would impact significantly on quality and access targets.

Monitor's view

87. The delivery of the submitted benefits in relation to acute general surgery is dependent on [redacted]. We note that Royal College guidance recommends that acute general surgery is located on the same site as an emergency department.⁴¹ In practical terms, this means that the delivery of benefits to acute general surgery patients in the long term would depend on [redacted].⁴² As discussed earlier in this advice, it is unclear what form emergency department reconfiguration will take, [redacted]. In these circumstances, we are not satisfied that the parties' proposed reconfiguration of acute general surgery services will deliver relevant customer benefits (in the form of higher quality services) in the long term.
88. Alternatively, if, as the parties submit, reconfiguration of acute general surgery can occur sooner and independently of any reconfiguration of emergency department services, then Monitor's view is that [redacted]. Further, the proposal will necessitate [redacted]. Further analysis on the likely effect of the parties' proposed reconfiguration on patient transfers is set out in Annex 3.
89. In our view, the merger is unlikely to deliver relevant customer benefits in the form of higher quality acute general surgery services for the following reasons:
- a. the benefits are dependent on [redacted], which may not occur;

⁴¹ The College of Emergency Medicine, *Emergency care 2015: building on the evidence* (2008) and *the way ahead 2008-2012 – strategy and guidance for emergency medicine in the United Kingdom and the Republic of Ireland* (2008).

⁴² [redacted].

- b. In the alternative, even if the proposed reconfiguration of acute general surgery services could occur sooner and independently of the reconfiguration of emergency departments, this [X].
90. In addition, we note that there is a lack of clarity about the likely effect of the proposed reconfiguration on interdependent services at each of the trusts (such as paediatrics, trauma orthopaedics, vascular and urology) which makes it difficult to assess the consequent effects on patients for these services.
91. In relation to the parties' submitted benefits regarding combining trainee surgeons onto a single rota, the parties have not provided detail such as the numbers of trainees likely to be shared between the trusts, or clinical evidence of the benefits of a shared trainee rota. The parties submit that they are not in a position to provide such granular levels of detail as trainee rotas at this stage given the complex interdependencies of clinical service provision that will inform the appropriate clinical rotas. However, in the absence of further detail we consider that there is insufficient evidence to accept this as a relevant customer benefit.

Cardiology Services

92. Currently, Bournemouth and Poole provide separate cardiology services at their respective sites.
- a. Bournemouth employs ten consultant cardiologists who work under a dedicated cardiology rota.⁴³ There is a consultant cardiologist on duty 24 hours a day, 7 days a week. Out of hours,⁴⁴ the consultant cardiologist is not present in the hospital but is on call to provide telephone advice or attendance as required. There is also a consultant ward round⁴⁵ on weekends. Bournemouth has a catheter laboratory which enables cardiac intervention⁴⁶ procedures to be performed.
- b. Poole does not have a dedicated cardiology rota and currently employs four cardiologists as part of an acute medical rota - that is, the rota consists of cardiologists and consultants of other medical specialties who provide general cover for all acute patients. There is limited availability of consultant cardiologists out of hours [X]. As Poole does not have a catheter laboratory, patients requiring cardiac intervention procedures are currently transferred to Bournemouth.

⁴³ This means that the rota solely comprises consultant and middle grade cardiology specialists and does not include doctors from other specialties.

⁴⁴ Out of hours is on weekends and after 6.00pm on weekdays.

⁴⁵ A ward round has been described as a 'complex process during which the clinical care of hospital inpatients is reviewed'. See Royal College of Physicians and Royal College of Nursing, *Ward rounds in medicine, principles for best practice* (October 2012). They provide an opportunity for the multidisciplinary team to come together to review a patient's condition, progress and develop a coordinated plan of care. The value of consultants' input into a patient's care, planning and treatment is described in Academy of Medical Royal Colleges, *The Benefits of Consultant Delivered Care* (January 2012).

⁴⁶ Interventional cardiology is the term used to describe a number of procedures performed by cardiology specialists in a cardiac catheter laboratory. Procedures such as the removal of blood clots from the arteries of the heart, or the use of balloons or stents to widen narrowed coronary arteries are carried out using catheterisation techniques under x-ray visualisation.

93. Post-merger, the parties propose to reconfigure cardiology services by:
- a. Establishing a combined cardiology rota that provides consultant cardiologist cover to both sites 24 hours a day, 7 days a week. Bournemouth will continue to have a consultant cardiologist on duty 24 hours a day, 7 days a week. A consultant cardiologist will be on site at Poole before 6.00pm on weekdays (as is currently the case) and, out of hours, the on-call cardiology consultant at Bournemouth will also provide telephone advice or attendance as required at Poole. In addition, the consultant ward rounds which currently occur on weekends at Bournemouth will be extended to Poole, and middle grade doctors who form part of the cardiology rota at Bournemouth will also provide out of hours on-call cover to Poole.
 - b. Establishing [X].
94. The parties note that the proposed reconfiguration of cardiology services would be subject to the consultation requirements set out in Annex 2. Should consultation support the parties' proposal, they submit that the reconfiguration is likely to be completed within the first year following the merger.
95. The parties submit that the proposed reconfiguration will deliver a higher quality cardiology service to patients at Poole by:
- a. Increasing their access to a cardiology consultant out of hours. Currently, patients at Poole do not have access to a consultant cardiologist for [X]% of out of hours' time. The proposed reconfiguration will provide cover by an on-call consultant for all out of hours' time. The parties submit that this will reduce mortality, length of stay and patients' waiting time for diagnosis and treatment.⁴⁷ In addition, the parties submit that the proposed reconfiguration will enable both Bournemouth and Poole to comply with the recommendations of the British Cardiovascular Society Working Group on Acute Cardiac Care.⁴⁸
 - b. Reducing the number of patients transferred from Poole to Bournemouth as patients with a primary cardiac problem will be directly admitted to Bournemouth. The parties

⁴⁷ See Myocardial Ischaemia National Audit Project (MINAP) Steering Group, *MINAP – How the NHS cares for patients with heart attack* (Ninth Public Report 2010); Birkhead JS, Weston C, Lowe D, *Impact of specialty of admitting physical and types of hospital on care and outcome for myocardial infarction in England and Wales during 2004-5: observational study* (British Medical Journal 2006). Data from the 2009-10 heart audit in England and Wales indicates that patients treated by cardiology teams, as opposed to general medical teams, had potentially lower mortality rates (6% versus 12%) and better follow up care. See The NHS Information Centre, *The NHS Heart Failure Audit 2010*.

⁴⁸ The British Cardiovascular Society recommends that patients presenting with acute cardiac conditions should be managed by a specialist, multi-disciplinary cardiac team and have access to key cardiac investigations and interventions, at all times. All hospitals admitting unselected acute medical patients should have an appropriately sized, staffed and equipped Acute Cardiac Care Unit, where high risk patients with a primary cardiac diagnosis should be managed. Access to these Acute Cardiac Care Units should be open to all high risk cardiac patients and in particular, should not be restricted to patients with Acute Coronary Syndrome. See *From Coronary Care Unit to Acute Cardiac care Unit – the evolving role of specialist cardiac care* (October 2011).

submit that this will also result in associated cost savings to taxpayers and commissioners (around £2 million), as commissioners currently pay a double admission charge for patients admitted to Poole who are subsequently transferred to Bournemouth.

96. The parties further submit that by combining cardiology services across both sites, the merged trust will have an increased ability to attract trainees and qualified staff and will be a stronger competitor to other hospitals providing cardiac services (such as University Hospital Southampton NHS foundation trust), than is currently the case.
97. The parties submit that, in the absence of the merger, it would not be feasible to increase consultant cover by agreeing a service level agreement to share the cardiology rota or [X]. This is because:
- a. Poole's cardiologists are currently part of a general medical rota, which means that establishing a joint cardiology rota would require consequent changes to the general rota. The parties submit that this would require a significant scale of collaboration, including the management of different rotas involving over 50 physicians, and the need to establish clinical accountability for emergency care. If the merger proceeds, the parties submit that they will fill the gaps in the general medical rota at Poole (left by the moving the four cardiologists to a cardiology rota) by establishing multiple specialty rotas (for example, gastroenterology/acute GI bleeding, stroke/thrombolysis).
 - b. Further, the parties submit that it is not feasible to enter into a service level agreement for the sharing of cardiology consultants as the parties' incentives are not aligned. That is, it would not be in Bournemouth's interests to extend consultant cover at Poole because it would increase consultant hours worked and potentially reduce revenue if Poole attracts cardiology patients away from Bournemouth. We note however that it would be possible to address the non-aligned incentives by agreeing on an appropriate fee.
 - c. Neither provider would support [X]. In addition the parties state that both sites will continue to receive large numbers of acute medical admissions via their emergency departments, so a large proportion of these will continue to require expert cardiac input or management.⁴⁹ The parties also submit that it would not be possible for Poole to increase its consultant cover in the absence of the merger by employing Bournemouth's consultants in their non-contracted hours because a number of consultants are already working 12 Programmed Activities⁵⁰ and therefore in excess of

⁴⁹ The parties submit that across the country about 40% of emergency medical admissions are related to acute cardiology.

⁵⁰ Programmed activities are essentially allocated time slots (of 4 hours each) for clinical and administrative duties, agreed in a consultant's individual job plan. 12 programmed activities per week is the maximum, which means a consultant is working full time and so is at his or her maximum capacity.

48 hours per week. We note that consultants are free to opt out of the European Working Time Directive⁵¹ and most do; the average week is 60 hours for a consultant.⁵²

98. The commissioners have indicated in writing that, in the absence of the merger, they would not be able to support a significant increase in cardiologists at Poole as this would not meet the requirements of the service specification which requires patients to be treated in a timely manner with the best evidenced treatment, e.g. primary percutaneous coronary intervention (PPCI). The commissioners state that this would mean that [redacted]. The letter also states that the commissioner could not support, in the absence of the merger, subsidising of any cardiology service to maintain financial viability as it would be unlikely that the service could be clinically sustainable. Commissioners state that the merger is likely to help to [redacted].

Monitor's view

99. There is strong evidence which supports the clinical benefits to patients of early review and specialist input by a cardiac expert, and indicates that this should be available on a round the clock basis.⁵³
100. We note that cardiology services in Dorset have been the subject of review for some time. A number of steps have already been taken to reconfigure services in the area, including to redirect patients requiring PPCI treatment and acute coronary syndrome patients to Bournemouth in future.
101. The Primary Care Trust Cluster in Dorset (NHS Bournemouth and Poole and NHS Dorset), together with Bournemouth, has requested that British Cardiovascular Intervention Society undertake a review of the local cardiac service. As we understand it, this review stems from an ongoing debate between the cardiologists at Bournemouth and the PCT over the last few years regarding the level of cardiac activity in Dorset, and their differing views in relation to the appropriate activity levels. In particular, we understand the commissioners are concerned that benchmarking data suggests that a high number of elective PCIs are being undertaken, while Bournemouth believes the PCI rate is appropriate based on the demographics of the area.
102. The objective of the review is to deliver an independent assessment of patient pathways and clinical practices, concluding either with confirmation that current practices result in the provision of appropriate, high quality cost effective services or with a set of recommendations for service change. Another objective of the review is to conduct a review of activity, concluding with an agreed activity plan. Commissioners told us that the review is likely to be completed by the first quarter of 2013/14 at the latest, and any reconfiguration would be

⁵¹ Which restricts hours worked to 48 hours per week, unless the employee agrees otherwise.

⁵² CCP, *Study of restrictions on consultants in relation to NHS work during non-contracted hours* (24 September 2009).

⁵³ The parties have submitted national evidence which supports the argument that patients treated by cardiology teams as opposed to general medical teams have potentially lower mortality rates and better follow up care. In addition the parties state there is considerable evidence that patients with cardiac problems benefit from rapid specialist assessment and diagnosis and this is supported by the recommendations of the British Cardiovascular Society Working Group on Acute Cardiac Care. See footnote 48 above.

likely to take at least 12 months to effect. Commissioners state that they will support the merged trust to rationalise services, and expect the provider's development plan to reflect the outcomes of the planned service review.

103. It appears to us that the review, and any commissioner led reconfiguration of cardiology services, is likely to have an impact on patient pathways and activity levels which may affect the available resources at both trusts. In these circumstances, it is not clear that increased cardiology consultant cover at Poole will be required post-merger, and, even if it is, it is difficult to identify at this stage which patients may ultimately benefit. In the context of the pending review of cardiology services, it is therefore difficult for Monitor to reach a view on whether the benefits of increased consultant cover are specific to the merger and would be unlikely to be delivered by any commissioner led reconfiguration of cardiology services.
104. Notwithstanding these difficulties, even if the proposed cardiology reconfiguration is delivered within the timeframe anticipated by the parties (within the first year following the merger, which is expected to complete between April and July 2013⁵⁴), Monitor's view is that any benefits arising from the proposed reconfiguration are likely to:
 - a. Be time-limited, that is, only likely to apply until any broader reconfiguration of patient pathways that occurs as a result of the cardiology review (that is within the first quarter of 2013/14). In this regard we note that the timing of the parties' proposed reconfiguration would coincide with the likely timing of any commissioner led reconfiguration.
 - b. Accrue to a limited category of patients (see the table below).

⁵⁴ Subject to satisfaction of conditions precedent.

	Pre-merger	Post-merger
Patients currently admitted directly to Bournemouth	Receive 24/7 consultant care and access to catheter laboratory	Unchanged
Patients currently transferred from Poole to Bournemouth (600 patients p.a.)		
Patients requiring PPCI treatment	200 patients transferred to Bournemouth p.a.	These patients will be directly admitted to Bournemouth regardless of the merger ⁵⁵
Acute coronary syndrome patients	Around 570 patients transferred to Bournemouth p.a.	These patients will be directly admitted to Bournemouth regardless of the merger ⁵⁶
Remaining patients	30 or fewer patients transferred to Bournemouth p.a.	[X]
Patients currently treated at Poole (who don't require transfer to Bournemouth)⁵⁷		
Patients with a primary cardiac problem	Treated at Poole	[X]
Patients with a secondary cardiac problem (e.g. inpatients under another specialty who develop a cardiac problem)	Treated at Poole	[X]

105. Under the parties' proposal:

- a. The quality of care delivered to patients at Bournemouth is likely to remain unchanged as a result of the merger, as these patients already receive cardiology consultant care 24 hours a day, 7 days a week.
- b. The quality of care delivered to patients admitted to Poole who are currently transferred to Bournemouth for treatment is also likely to be unaffected by the merger, as the majority of these patients will be directly admitted to Bournemouth in future, regardless of whether the merger proceeds. Of the 600 patients who are currently transferred from Poole to Bournemouth each year:
 - i. 200 of these patients will no longer be admitted to Poole following the introduction of PPCI treatment at Bournemouth in October 2012; that is,

⁵⁵ These patients will be admitted directly to Bournemouth once PPCI treatment is introduced at Bournemouth in October 2012, regardless of whether the merger proceeds.

⁵⁶ These patients will be admitted directly to Bournemouth pursuant to the plans of the Dorset Network Cardiovascular CCG, regardless of whether the merger proceeds.

⁵⁷ The parties submit that Poole admits 860 inpatient spells under a consultant cardiologist who are not transferred to Bournemouth. Cardiology inpatients are defined as patients under specialty 320 at any point during their spell. In addition, the parties submit that approximately 30% of the 7495 non-elective patients admitted to Poole under 'general medicine' or 'acute medicine' codes in 2011/12 required some form of cardiology-related care. Given that these patients were not admitted under code 320 we have not been able to verify the accuracy of the parties' estimate regarding the number of patients affected. Nor have the parties provided details of the type of cardiology care that was provided and whether this was provided by a consultant.

patients who would otherwise present at Poole with an electrocardiogram⁵⁸ confirmed heart attack will be taken directly to Bournemouth for intervention.

- ii. In any event, over 95% of the 600 patients will no longer be admitted to Poole in future pursuant to the plans of the Dorset Network Cardiovascular Clinical Commissioning Group, which require acute coronary syndrome patients to be directly admitted to Bournemouth.
 - c. The patients who are currently treated [X] may derive some benefit from increased consultant cover post-merger. Under the parties' proposal:
 - i. All patients presenting at Poole with a primary cardiac problem [X].
 - ii. Patients at Poole who do not have a primary cardiac problem (for example, inpatients under another specialty who develop a cardiac problem) [X]. These patients may benefit from increased access to an out of hours consultant.
106. We note that the parties submit that many of these patients can be managed by a physician with input from a cardiologist, and for these patients the increased out of hours care will complement the in-hours consultant care that they already receive regardless of the merger.
107. We do not agree with the parties' submission that the merger will reduce the number of patients transferred from Poole to Bournemouth and eliminate the duplicative fees associated with the double admission of these patients as the majority of these (over 95%) will be directly admitted to Bournemouth regardless of the merger, pursuant to the plans of the Dorset Network Cardiovascular Clinical Commissioning Group.
108. We asked the parties whether the redirection of patients from Poole to Bournemouth that will occur regardless of the merger is likely to create spare capacity for Poole's cardiology consultants which may be used to increase out of hours cover in the short term. The parties submit this cannot be achieved because there are only four cardiologists at Poole and a 1 in 4 rota is not sustainable.
109. We do not agree with the parties' submission that the merger will increase the merged trust's ability to attract trainees and qualified staff due to the integration of services, including PPCI cardiac services, across both sites. We note that PPCI services will continue to be offered from one site only post-merger. The parties submit that there are particular strengths of the cardiology department at Poole especially in stress echo and academic research which are both lacking at Bournemouth and which may be attractive to cardiologists in training and to physiologists. However, in our view there are many factors that may be relevant to attracting

⁵⁸ Electrocardiogram (ECG) is a recording of the electrical activity of the heart produced by placing electrodes on the skin of the chest which are then connected to a machine. A printed graph of the heart's activity is produced. An ECG can detect areas of heart muscle deprived of oxygen and/or dead tissue. The initial diagnosis of a heart attack is usually made through observation of a combination of clinical symptoms and characteristic ECG changes.

trainees and qualified staff and it is not clear to us what the impact of stress echo and academic research is for recruitment, particularly in light of [X].

110. The parties also submitted that the merger will improve the competitiveness of the merged trust and consequently benefit patients. Other than as set out above, the parties have not explained how improved competitiveness would result in benefits to patients in the form of lower prices, or higher quality, greater choice or innovation of services. Accordingly our view is that this does not constitute a relevant customer benefit.
111. In relation to commissioners' submission that the merger will help to [X], we acknowledge that there may be interdependencies between cardiology and other clinical services. However, in the absence of further detail about the likely impact of the cardiology reconfiguration on other services we consider that there is insufficient evidence to accept this as a relevant customer benefit.
112. In our view, the parties' proposed reconfiguration of cardiology services may deliver relevant customer benefits in the form of improved quality of service by providing increased consultant cover. However, we note that pursuant to commissioner plans, PPCI and acute coronary syndrome patients will be redirected to Bournemouth regardless of the merger and [X]. In these circumstances, any benefit that may accrue as a result of the merger is likely to:
 - a. Be time limited: that is, only likely to apply until any broader reconfiguration of patient pathways that occurs as a result of the cardiology review;
 - b. Only affect a limited category of patients: that is, only patients who would, [X], be treated at Poole stand to benefit from increased out of hours consultant care. This complements the in-hours consultant care that they already receive regardless of the merger.

DELIVERY OF FINANCIAL SAVINGS THROUGH ECONOMIES OF SCALE

113. The parties submit that they are likely to achieve merger-related savings of around £[X] million between 2013/2014 and 2015/2016. They submit that their status as not for profit organisations that exist to serve their patients' interests, combined with regulatory obligations to operate efficiently, means that all savings will be reinvested in patient care. They submit that the savings are relevant customer benefits because they will use the savings to protect and improve the quality of services and benefits will thereby accrue directly to patients as a result of the merger.
114. For the purposes of our assessment, we have focused on the savings identified as being dependent on the merger (i.e. £[X] million).⁵⁹ The largest component of these savings is the £[X] million saving from reducing length of stay. The description provided for this saving is [X]. The parties submit that beds will be reduced through sharing best practice between

⁵⁹ The parties identified a further £13.6 million as highly unlikely to be delivered without the merger, that is, savings which may be technically possible to achieve as two separate organisations but would be more likely to be delivered under the direction of a single governing body.

providers, by reducing short stay patients and introducing a new treatment and investigations unit at Bournemouth. However, in order to evidence these savings we would expect to see a business case or implementation plan that describes and explains how the savings will be achieved.

115. Other savings submitted include £[X] million from [X]. The parties explain that [X]. The parties did not explain what the change in clinical practice is or how the efficiency gain will be achieved. There is also no explanation as to why [X]. In order to evidence these savings we would expect to see an analysis of bed usage in the two departments and how that would be done differently post-merger. We would also expect to see implementation plans or business cases that have been developed.
116. In our view the parties' assertions are not sufficient to support the submitted savings. In addition to this the parties submit that savings of up to £[X] million are possible through reducing the overlap in corporate functions through a single Board as well as moving to single back office systems, such as finance and human resources. We do not accept the parties' submission that the savings from the integration of back office functions are dependent on a merger between geographically proximate parties. Although the parties state there is some evidence that the proximity of management and corporate functions to the clinical services they support is important, the parties have not provided or cited this evidence. In our view, back office savings could be delivered in a number of ways, for example by a merger with an alternative provider.

IMPROVED SCOPE OF SERVICES

117. The parties submit that the current configuration of service provision at both trusts is clinically and financially unsustainable. They state the scale of each organisation inhibits them from being able to offer around the clock access to expertise within a number of specialties as recommended by Royal Colleges. They add that this makes recruitment difficult and results in an over reliance on temporary staff.
118. In addition the parties submit that they are independently relatively small in NHS terms with incomes of £190 million and £230 million. Although they acknowledge that challenges around scale exist for most small sized NHS trusts, they submit this is exacerbated in their case as the service portfolio offered within each trust is unbalanced, in terms of the mixture of elective and non-elective work and the bias towards certain specialties. The parties state that mandatory service provisions (such as emergency care) are unprofitable and this leaves the trusts vulnerable if there is an inability to cross subsidise one area of activity with another.
119. The parties submit that the merger will allow the new entity to provide a comprehensive range of elective and non-elective services on an around the clock basis. They submit that the improved scope of services will enable them to recruit, retain and train key clinical staff, with greater volumes of activity and expanding the range of sub-specialties making the organisation a more attractive place to train and work. Further, they submit that the benefits will directly affect patients as they will have increased access to appropriate clinical care, and

there will be a reduced risk of financial pressures on the organisation impacting delivery of services.

120. With the exception of the services discussed earlier in this paper, the parties have not specifically identified other services in which around the clock consultant cover is likely to be provided as a result of the merger. The parties have not provided details of how this benefit will be realised in relation to services other than cardiology, emergency, acute general surgery, haematology and maternity, for example by discussing which services are likely to be improved and how the merger will change service delivery. Nor have the parties indicated that the sustainability of other particular services is likely to be threatened in the absence of the merger. On this basis, our view is that there is insufficient evidence for this benefit to be accepted.

ENHANCED ABILITY TO RAISE CAPITAL

121. The parties submit that there is a need to invest in [§<] clinical services at Poole, such as maternity and haematology, but that Poole does not have the financial means to enable such an investment because of the prudential borrowing limit which places a cap on the amount a foundation trust is able to borrow.⁶⁰ In addition the parties state that [§<]. The parties state the merger will enhance the merged trust's ability to raise capital, as it will have an estimated borrowing capacity of around £[§<] million. The parties submit that they will have the ability to redirect necessary capital resources from Bournemouth (which has a surplus) to Poole as part of the wider service reconfiguration plans. They argue that they would utilise this ability to secure capital loans to invest in [§<].
122. In order to constitute a relevant customer benefit under the Enterprise Act, the benefit must be in the form of lower prices, higher quality, greater choice or innovation of goods or services for relevant customers. With the exception of the proposed reconfiguration of haematology and maternity services which have in any event been examined separately above, the parties have not demonstrated how any increased borrowing capacity will be passed on as a benefit to relevant customers. We also note that any borrowing has an opportunity cost and the parties have not demonstrated the relative value that they would obtain from investing the borrowed funds as a merged trust, as against the relative value that could be obtained from investing the borrowed funds as separate providers. We do not consider that increased borrowing capacity is in itself a benefit, particularly in a challenging financial environment. Therefore our view is that this does not constitute a relevant customer benefit.

CONCLUSION

123. Monitor's views on the benefits submitted by the parties are as follows:
- a. The parties' proposed reconfiguration of maternity services may deliver relevant customer benefits to some patients in the form of improved quality of service by

⁶⁰ Monitor sets the prudential borrowing limit based on the Prudential Borrowing Code and specifies the prudential borrowing limit in each foundation trust's terms of authorisation.

eliminating patient transfers [X] and increasing midwife cover at Poole [X]. However, we note that [X].

- b. The parties' proposed reconfiguration of haematology services does not deliver relevant customer benefits (in the form of improved quality of haematology services [X]) because these benefits are likely to be delivered by commissioner led reconfiguration of haematology services.
- c. The parties' proposed reconfiguration of emergency departments does not deliver relevant customer benefits (in the form of improved quality of service by providing increased consultant cover) because the benefit will not be delivered unless [X]. The merger parties cannot achieve this without the consent of the commissioners. Commissioners are currently undertaking a review of urgent care services which will inform what the requirements should be for emergency care and emergency departments across the area and will occur regardless of the merger.
- d. The parties' proposed reconfiguration of acute general surgery does not deliver relevant customer benefits (in the form of improved quality of service [X]). Therefore, either the ability to reconfigure acute general surgery is dependent on the reconfiguration of the parties' emergency departments, or if it could occur sooner and independently of the reconfiguration of emergency departments, [X].
- e. The parties' proposed reconfiguration of cardiology services may deliver relevant customer benefits in the form of improved quality of service by providing increased consultant cover. However, we note that pursuant to commissioner plans, PPCI and acute coronary syndrome patients will be redirected to Bournemouth regardless of the merger. Commissioners are also conducting a review of cardiology services in the area which will determine the nature of any further reconfiguration required. In these circumstances, any benefit that may accrue as a result of the merger is likely to:
 - i. Be time limited: that is, only likely to apply until any broader reconfiguration of patient pathways that occurs as a result of the cardiology review;
 - ii. Only affect a limited category of patients: that is, only patients who would, [X], be treated at Poole stand to benefit from increased out of hours consultant care. This complements the in-hours consultant care that they already receive regardless of the merger.
- f. The financial savings which the parties submit will result from the merger do not constitute relevant customer benefits because the savings have not been sufficiently evidenced. In addition to this, the back office savings submitted by the parties may be delivered by a merger with an alternative provider.
- g. The improved scope of services which the parties submit the merger will deliver does not constitute a relevant customer benefit because the parties have not provided

sufficient detail about how this benefit will be realised in relation to services other than cardiology, emergency, acute general surgery, haematology and maternity.

- h. The parties' enhanced ability to raise capital does not constitute a relevant customer benefit because, with the exception of the proposed reconfiguration of haematology and maternity services which have in any event been examined as separate benefits, the parties have not demonstrated how any increased borrowing capacity will be passed on as a benefit to relevant customers.

Outline of Monitor's process

On 22 June 2012, the OFT notified Monitor, under section 79(4) of the Health and Social Care Act that the OFT had decided to carry out an investigation of the merger under Part 3 of the Enterprise Act.

In providing this advice, Monitor sought input from the Co-operation and Competition Panel members and Clinical Reference Group.⁶¹

Monitor engaged with the parties in relation to their benefits case during the period of pre-notification discussions between the parties and the OFT as well as since the OFT commenced its public investigation of the merger on 22 October 2012.

Monitor obtained evidence through written information requests to the parties and the relevant commissioners (NHS Bournemouth and Poole PCT and Dorset Shadow CCG). Monitor also held meetings (by phone and in person) between the merger parties and the Clinical Reference Group of the Co-operation and Competition Panel and between the relevant commissioners and Monitor staff. Notes of these meetings were prepared by Monitor staff and sent to the merger parties to check for factual accuracy.

On 30 November 2012, Monitor provided the merger parties with its provisional view on the relevant customer benefits arising from the merger. The parties were invited to comment on this provisional view. Monitor took into account the parties' response to the provisional view, and held a further meeting (by phone) with commissioners to clarify matters that were raised in the parties' response.

⁶¹ The Clinical Reference Group provides expert clinical advice on issues under consideration by the Co-operation and Competition Panel. It consists of several clinicians with expertise in various clinical areas. A list of the members of the Clinical Reference Group and the Co-operation and Competition Panel members is available on the Co-operation and Competition Panel's website <http://www.ccpnl.org.uk>.

Consultation requirements for reconfiguration of NHS services

The parties submit that the proposed reconfigurations to their services are not a commitment to specific change, and will only be undertaken after due consideration of:

- The statutory obligation under section 242 of the National Health Service Act 2006 (as amended) to engage and/or formally consult when considering changes to the way in which services are provided or the range of services they intend to provide. From 1 April 2013 consideration will also have to be given to the obligations imposed on the NHS Commissioning Board and Clinical Commissioning Groups, in sections 13 and 14 of the National Health Services Act 2006.
- Section 244 of the National Health Service Act 2006, which requires all relevant NHS bodies to consult with their local Health Overview and Scrutiny Committee, when undertaking any substantial variation or substantial development of the health service in the Health Overview and Scrutiny Committee's area.
- Their obligations under the Equality Act 2010, including having due regard to the general equality duty imposed under section 149 of the Equality Act 2010.
- The four key tests set out in the revised Operating Framework for 2010/11, which require existing and future reconfiguration proposals to demonstrate:
 - Support from GP commissioners
 - Strengthening public and patient engagement
 - Clarity on the clinical evidence base, and
 - Consistency with current and prospective patient choice.

The parties submit that they understand and will comply with their statutory obligations when seeking to make decisions over service reconfiguration.

Likely effect of the parties' proposed reconfiguration of acute general surgery services on patient transfers

The parties submit that they can complete their proposed reconfiguration of acute general surgery within the first year following the merger, independently of any reconfiguration of their emergency departments. In practical terms this means that [REDACTED].

Currently, the breakdown of patients admitted to Poole and Bournemouth for acute general surgery is as follows:

Admitted via	Bournemouth	Poole
Emergency Department	42%	50%
General Practitioner Referrals	49%	45%
Other (for example, transfer from another acute provider or direct from a consultant clinic)	9%	5%

The parties submit that post-merger, patients admitted to the emergency department [REDACTED] during the day can be treated by surgeons doing elective surgery at the site. We consider that the merger is unlikely to deliver benefits to these patients compared with the pre-merger situation as they will not receive acute general surgery services from consultants without elective commitments. [REDACTED].

Patients admitted out of hours⁶² will require [REDACTED]. Currently, Poole performs around 480 emergency procedures out of hours each year and Bournemouth performs around 580. The parties submit that in future the number of patients requiring [REDACTED] out of hours is likely to be reduced by [REDACTED] as [REDACTED], resulting in effective triage and the patient being taken to the correct site. Overall, the parties estimate that 12-20% of the current total number of emergency procedures across both hospitals out of hours (that is, between 128 and 212) is likely to require [REDACTED]. These out of hours patients will have access to [REDACTED].

⁶² Out of hours is between 8pm and 8am on weekdays and all day on weekends.

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© Monitor (February 2013)

Publication code: IRREP 01/13

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